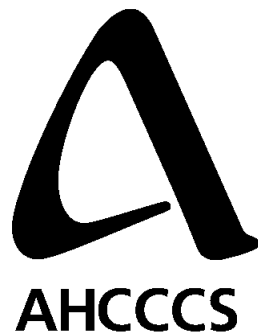


# **Chapter 8**

## **Authorizations**



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## GENERAL INFORMATION

Many non-emergent services require prior authorization from the AHCCCS Administration, either from the Prior Authorization Unit for acute care services or from the recipient's case manager for ALTCS services.

Determination for prior authorization (PA) for acute services is based upon:

- ☒ The recipient's eligibility status at the time of the PA request,
- ☒ The provider's status as an AHCCCS-registered fee-for-service provider, and
- ☒ The service's status as an AHCCCS-covered service that requires PA.

PA for specific services from the AHCCCS PA Unit or the ALTCS case manager is required for all fee-for-service recipients, including fee-for-service Indian Health Service recipients, unless:

- ☒ The recipient has Medicare, third party liability (TPL), or commercial insurance coverage *and* the services are covered by Medicare, TPL, or commercial insurance, or
- ☒ Services were provided prior to posting of recipient retroactive eligibility, or
- ☒ Services are provided by an IHS facility, or
- ☒ The service is an emergency.

Issuance of an authorization does not guarantee payment. The medical condition for which the authorization was issued must be supported by medical documentation, and the claim must be otherwise clean and timely submitted.

## PRIOR AUTHORIZATION PROCEDURES

Providers may phone or fax the AHCCCS PA Unit to request authorization. To obtain PA by telephone, providers must call between 8:30 AM to 4:30 PM , Monday – Friday:

(602) 417-4400 (Phoenix area) Providers in area codes 602, 480, and 623 **must** use this number.

1-800-433-0425 (within Arizona) This number is blocked for callers in area codes 602, 480, and 623.

1-800-523-0231 (outside Arizona)

The AHCCCS PA Unit's fax number is (602) 256-6591.

The fax number for *transportation providers only* is (602) 417-4687.

## **PRIOR AUTHORIZATION PROCEDURES (CONT.)**

Providers who fax documentation to the AHCCCS PA Unit should ensure that a cover sheet accompanies the documentation. The cover sheet should list the provider's name and AHCCCS provider ID number, the name of a contact person, a telephone number, and a fax number. Without such information, authorization may not be established, and claims for services may be denied.

Whether requesting information by telephone or fax, providers should be prepared to supply the following information:

- ☒ Requester's name
- ☒ Provider's name and NPI (if applicable) or AHCCCS ID number
- ☒ Recipient's name and AHCCCS ID number
- ☒ Type of service and service date(s)
- ☒ ICD-9 CM diagnosis code
- ☒ CPT/HCPCS/ADA procedure code (if applicable)
- ☒ Tier level (if applicable)
- ☒ Estimated charges/professional services (if there is no AHCCCS fee schedule)
- ☒ Medical justification for services

An AHCCCS PA nurse will either issue an approval, a denial, or a provisional PA number pending the receipt of required documentation to substantiate compliance with AHCCCS criteria.

AHCCCS generates a PA confirmation letter with appropriate approval, denial, or provisional information (See Exhibit 8-1). The letter is mailed to the provider by the next working day. When a PA is denied, AHCCCS also generates a denial letter that is sent to the recipient within three working days of the request.

## **CLAIM SUBMISSION DIRECTIONS**

It is not necessary for the provider to enter the PA number on the claim form. If a valid PA exists for the service, the AHCCCS claims system will automatically match the claim information against established PAs and choose the correct one.

The information entered on the claim form must match what has been prior authorized and listed on the PA confirmation letter. If there are any discrepancies, the system will not find the appropriate PA, and claim will be denied. Providers may call the PA Unit prior to submitting a claim to correct any discrepancies.

## **PRIOR AUTHORIZATION OF ACUTE SERVICES**

The following list identifies acute services requiring prior authorization. ALTCS authorization requirements are discussed in Chapter 21, ALTCS Services.

- ☒ Abortions
- ☒ Ambulatory surgery centers
- ☒ Apnea management and training
- ☒ Behavioral health services
- ☒ Dental services
- ☒ Dialysis (FES recipients must have extended services plan)
- ☒ DME and supplies
- ☒ Home health services
- ☒ Hospital admissions
- ☒ Hysterectomy services
- ☒ Inpatient services
- ☒ Non-emergency transportation
- ☒ Nursing facilities
- ☒ Observation services
- ☒ Podiatry
- ☒ Rehabilitative services
- ☒ Surgeons
- ☒ Total parenteral nutrition (TPN)

## **AUTHORIZATION REQUIREMENTS FOR SPECIFIC SERVICES**

### ☒ Abortions

- ✓ All medically necessary abortions require PA except in cases of medical emergency.
  - ☒ In the event of a medical emergency, all documentation of medical necessity must accompany the claim when submitted for reimbursement.
- ✓ The request for PA must be accompanied by a completed Certificate of Medical Necessity for Pregnancy Termination (See *AMPM*, Exhibit 410-1).
- ✓ The AHCCCS PA Unit will review the request and the certification and shall authorize the procedure if medically necessary.

### ☒ Ambulatory surgery centers

- ✓ Ambulatory surgical facilities furnishing non-emergency surgical services must obtain a PA number for scheduled ambulatory surgery except voluntary sterilization procedures.
- ✓ The PA number is separate from the surgeon's PA number.

### ☒ Apnea management and training

- ✓ Apnea management, training, and use of the apnea monitor must be billed using procedure code E0618 or E0619 and the RR modifier and must be prior authorized.
- ✓ PA requests must include the charge for the service, including the charges for management, training, and use of the apnea monitor.

### ☒ Behavioral health services

- ✓ For non-Medicare recipients enrolled with a Tribal ALTCS program contractor, notification of an admission into an acute hospital or an acute care psychiatric hospital must be made to the AHCCCS Prior Authorization Unit.
- ✓ For all other behavior health services, see Chapter 19, Behavioral Health Services.

### ☒ Dental services

- ✓ PA is not required for emergency dental services for all recipients nor for preventive/therapeutic dental services for EPSDT recipients.
- ✓ Medically necessary dental surgery services for EPSDT recipients require PA.
- ✓ Medically necessary dentures
  - ☒ Provision or replacement, repairs or adjustment of dentures, and provision of obturators and other prosthetic appliances for restoration or rehabilitation, provided to adults require PA.

## **AUTHORIZATION REQUIREMENTS FOR SPECIFIC SERVICES (CONT.)**

- ☒ Dental services (Cont.)
  - ✓ Pre-transplant dental services that are medically necessary in order for the recipient to receive the major organ or tissue transplant require prior authorization from the AHCCCS transplant case manager.
- ☒ Dialysis
  - ✓ PA is not required for monthly dialysis supervision or services. See Chapter 15.
- ☒ DME and supplies
  - ✓ DME and prosthetic/orthotic devices when the value for the item exceeds \$300 require PA.
  - ✓ Consumable medical supplies (supplies which have limited potential for re-use) require PA when the cost exceeds \$100 per month.
- ☒ Home health services
  - ✓ All home health services for acute care recipients require PA.
  - ✓ All home health services for ALTCS recipients require case manager authorization.
- ☒ Hospital admissions
  - ✓ Prior authorization is required prior to all non-emergency and elective admissions.
  - ✓ Notification to the PA Unit must be provided no later than the fourth day of an emergency hospitalization or fourth day of an ICU stay.
    - ☒ If the required notification day falls on a weekend or state holiday, notification must be provided no later than the next working day.
    - ☒ If approved, the PA nurse will authorize the length of stay.
    - ☒ Authorization will also cover the first three days of the emergency admission or the first 72 hours of the ICU admission if medically appropriate.
    - ☒ Continued authorization/approval of services is determined through concurrent review.
    - ☒ Providers should not split bill these claims.

## **AUTHORIZATION REQUIREMENTS FOR SPECIFIC SERVICES (CONT.)**

### ☒ Hospital admissions (Cont.)

- ✓ When a recipient's eligibility is posted after the beginning date of service and prior to the end date of service on the claim:
  - ☒ Notification must be provided no later than the fourth day after the eligibility posting date of an emergency hospitalization or the fourth day after the eligibility posting date of an ICU stay.
  - ☒ If the required notification day falls on a weekend or state holiday, notification must be provided no later than the next working day.
  - ☒ This policy does not apply if any eligibility is posted at the time services are rendered and there is a subsequent posting of retroactive eligibility.
  - ☒ If notification is not provided as required, AHCCCS may deny any portion of the stay dependent on medical review.

### ☒ Hysterectomy services

- ✓ Non-emergency hysterectomy services require PA.
- ✓ In a life-threatening emergency, PA is not required, but the physician must certify in writing that an emergency existed.

### ☒ Inpatient services

- ✓ Prior authorization is required for:
  - ☒ Podiatry services when ordered by the primary care physician.
  - ☒ Detoxification services (only levels 3 and 4 are covered).
  - ☒ All organ and tissue transplantation services.

### ☒ Non-emergency transportation

- ✓ Non-emergency transportation provided by ground ambulance, air ambulance, and non-ambulance vehicles require PA.
- ✓ Only codes for the base rate, mileage, and waiting time will be prior authorized.
- ✓ See Chapter 14, Transportation Services

## **AUTHORIZATION REQUIREMENTS FOR SPECIFIC SERVICES (CONT.)**

### ☒ Nursing facilities

- ✓ PA must be obtained before admission of an acute care recipient unless the recipient becomes retroactively eligible for AHCCCS.
  - ☒ No PA is required during the retro period, but the stay is subject to medical review.
- ✓ Initial authorization will not exceed the recipient's anticipated fee-for-service enrollment period or a medically necessary length of stay; whichever is shorter.
- ✓ Reauthorization for continued stay is subject to concurrent utilization review by AHCCCS or its designee.
- ✓ AHCCCS will allow up to 90 days of nursing facility care in a contract year (10/01 – 09/30).
- ✓ Physical, occupational, and speech therapy must be prior authorized for acute care recipients in nursing facilities.
- ✓ As a part of discharge planning, prior authorization staff may request hospital personnel to initiate an ALTCS application for potentially eligible recipients.

### ☒ Observation services

- ✓ Extensions to the 24-hour limit for observations services must be prior authorized.

### ☒ Pharmacy

- ✓ See Chapter 12, Pharmacy Services for PA information.

### ☒ Podiatry services

- ✓ Podiatrists must obtain prior authorization before providing podiatry services including inpatient podiatry services ordered by the primary care provider.

### ☒ Rehabilitative services

- ✓ All outpatient physical therapy services (speech therapy and occupational therapy are not covered for non-ALTCS recipients over age 21) require PA unless:
  - ☒ Services are for EPSDT recipients, or
  - ☒ Therapy is a result of an emergency outpatient visit

## AUTHORIZATION REQUIREMENTS FOR SPECIFIC SERVICES (CONT.)

### ☒ Rehabilitative services (Cont.)

#### Example:

A recipient breaks a leg and is placed in a hip to toe cast.

If the recipient has never used crutches before, the hospital may send the recipient to therapy for a brief period of time to learn how to walk on crutches. This would be billed on the outpatient claim and would not require PA. However, if the recipient were instructed to return to the hospital for future therapy, this would require PA.

Similarly, physical therapy rendered in a physician's office as part of an emergency treatment does not require prior authorization. However, if the recipient were instructed to return for future therapy, this would require PA.

### ☒ Surgeons

✓ Surgeons must obtain a separate and distinct PA from that of the hospital for:

- ☒ Elective or non-emergency inpatient or ambulatory surgery, except sterilization
- ☒ Both the primary surgical procedure and any surgical procedure designated in the *CPT Manual* as a separate procedure
- ☒ Surgeries scheduled more than 72 hours after initial emergency admission of a continuous hospitalization
- ☒ Scheduled cesarean deliveries
- ☒ Organ transplantation not covered by Medicare

✓ Assistant surgeons and anesthesiologists do not require separate PAs.

### ☒ Total parenteral nutrition (TPN)

- ✓ Facilities and agencies furnishing outpatient TPN services must obtain PA at least one working day prior to initiation of services.
- ✓ Telephone requests are given provisional PA.

## **AUTHORIZATION REQUIREMENTS FOR SPECIFIC SERVICES (CONT.)**

- ☒ Total parenteral nutrition (Cont.)
  - ✓ The following documentation must be received by the AHCCCS PA Unit within five working days of the initial TPN authorization request:
    - ☒ History and physical which describe recipient's condition and diagnosis
    - ☒ Physician's orders
    - ☒ Dietary assessment, including recipient's weight
    - ☒ Any pertinent progress notes (nursing/physician) which reflect the recipient's dietary, eating, and functional status
    - ☒ Physician progress notes indicating expected outcome of treatment
    - ☒ Nursing home records showing percentage of recipient's meal consumption

### **IHS**

AHCCCS recipients who are enrolled with Indian Health Service (IHS) or 638 tribal providers may receive services from AHCCCS fee-for-service providers if the services are not available through IHS or the tribal facility.

Non-IHS/638 tribal providers must obtain authorization from the AHCCCS PA Unit before they can provide certain medically necessary services to IHS/tribal recipients, refer to the FFS prior authorization list.